

especially amongst those with a non-malignant diagnosis, more clearly needs to be done.

Recommendations from this study suggest staff require palliative and end of life care training, including identifying when death is approaching, along with communication skills training in order to instigate timely conversations with patients and their family members. In addition, further research in this area is highly recommended.

P-182 **RETROSPECTIVE SURVEY OF PRACTICE OF CARE PROVIDED TO PATIENTS WITH NEURODEGENERATIVE CONDITIONS**

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Background Palliative care involvement in supporting patients with a neurodegenerative condition has increased. There are no set standards of what support palliative care services specifically should provide for these patients. There are several sources available that outline recommended areas to be addressed (Olivera, Borasioc, Caraceni, et al. *Eur J Neurol*. 2016; 23(1):30–8; Vincent Scott, Lisney. *Multiple System Atrophy pathway*. MSA Trust, 2015; PSPA. A professionals guide to progressive supranuclear palsy. 2020). Overall themes from these sources are:

- Good advance care planning (ACP).
- Capacity assessments.
- Symptom assessment and control (SC).
- Psychological support.
- Carer support.
- MDT access.
- Home environment modification.
- Access to hospice services.

Aims To benchmark our service against the above recommendations. To identify gaps and propose ways in which to fill these gaps for the future.

Methods Stage 1. Literature review and correspondence with tertiary neurology centres. Identification of assessment criteria, creation of data collection proforma and method for analysis, e.g. for SC reviewing the use of the standard Integrated Palliative care Outcome Scale (IPOS) (Murtagh, Ramsenthaler, Firth, et al. *Palliat Med*. 2019; 33(8):1045–1057) and assessment for symptoms using IPOS for long-term neurological conditions (LTNC) (Wilson, Hepgul, Saha, et al. *Sci Rep*. 2019; 9(1):4972). Stage 2. Random selection of patients' electronic notes over previous 2 years reviewed, and results analysed.

Results Ten sets of patient notes analysed, with diagnoses; Parkinson's disease, multiple system atrophy or progressive supranuclear palsy. Holistic teams involved per patient; range 3–10. SC; IPOS in 1 year 90%, but assessment of saliva issues or spasms only 30%. Carer needs; offered assessment 87.5%. Psychological needs assessed and supported 100%. MDT discussion; 90%. Assessment of home environment; 100%. Cognition; formal cognitive assessments done 0%, comment on cognition 70%, appropriate capacity assessments done 67%. ACP; identifying need to discuss resuscitation 100%, good ACP discussion 78%, ACP revisited in past year 67%, treatment escalation plan recently updated 40%, gastrostomy discussions 40%.

Conclusions Areas of good practice and areas for improvement identified. Suggestions being worked on include introduction of the IPOS for LTNC and cognitive assessments.

P-183 **WITHDRAWAL OF MECHANICAL VENTILATION IN MOTOR NEURONE DISEASE: AN UPDATED EVALUATION OF PRACTICE**

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Background Withdrawing mechanical ventilation at the request of a patient with motor neurone disease is complex and challenging. In 2015, the Association for Palliative Medicine (APM) published widely endorsed guidance for healthcare professionals (Faull. Withdrawal of assisted ventilation at the request of a patient with motor neurone disease. APM). We will discuss the updated results of an anonymised data set provided by professionals who have utilised the guidance across the United Kingdom.

Methods Excel analysis of a core data set, defined in the APM guidance, and thematic analysis of free-text comments, submitted by UK-based healthcare professionals soon after withdrawal of mechanical ventilation in any care setting, including inpatient hospice and at home. This is an updated analysis following previously published work (Faull, Wenzel. *BMJ Support Palliat Care*. 2022; 12(e6):e752–e758).

Results Eighty-one data sets were submitted by fifty-eight professionals from across the UK. Frequency and dosage of opioid and sedative medication required pre- and post-withdrawal of the mechanical ventilation was similar to that shown in previous analysis. Ten patients lived for longer than eight hours following withdrawal of mechanical ventilation. These patients were of varying ages and had varying dependency on mechanical ventilation prior to withdrawal. All ten patients were using non-invasive ventilation as opposed to tracheal ventilation.

Discussion The updated results of this evaluation of practice provide new information on patients who have a prolonged time to death following withdrawal of mechanical ventilation in motor neurone disease. We will discuss the reported experiences of healthcare professionals, as well as the experiences of family members and the implications for service delivery particularly when there is a longer time to death following withdrawal.

P-184 **MUSIC AND MOVEMENT FOR PEOPLE WITH PARKINSON'S DISEASE AND THEIR CARERS: A DALCROZE EURHYTHMICS PILOT STUDY WITHIN A HOSPICE ENVIRONMENT**

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There is a growing call for embodied, non-invasive approaches to rehabilitation which can improve social relationships as well as psychological and physical wellbeing. This call is supported by an emerging evidence base demonstrating the impact of psychosocial approaches, including music and movement,

already found to be beneficial to those with neurological and other disorders.

This practice-led study aimed to explore how a pilot music and movement project was experienced by people with Parkinson's disease and their carers within a hospice environment. Over two months, we offered six weekly sessions as part of the expanding Wellbeing service at St Columba's Hospice Care. Eight people with Parkinson's disease and five carers participated. The study followed a specific music and movement approach (Dalcroze Eurhythmics) that, in addition to psychosocial aspects, considers physical functions of balance and gait as well as executive functions and alertness and concentration. Data collection involved baseline participant information, weekly ethnographic participant observation, as well as a participant focus group and an interview with the facilitator at the end of the project.

The findings highlight the perceived impact of music and movement on people's sense of psychosocial and physical wellbeing. Participants' reports of physical and psychological safety, their re-connection with their sense of self, experiences of joy and playfulness, and the relational reframing of movement transcending functional limitations are some examples of emerging thematic areas. These findings are discussed in relation to contemporary literature to consider strengths and drawbacks for service development in this area of work for hospices.

P-185 **USE OF HIGH FLOW NASAL OXYGEN ON A HOSPICE INPATIENT UNIT (IPU) FOR SYMPTOM CONTROL IN PATIENTS WITH INTERSTITIAL LUNG DISEASE**

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Background Interstitial Lung Disease (ILD) can have a rapidly progressive course with hypoxaemic respiratory failure, intolerable breathlessness and anxiety at end of life. Often, morphine and midazolam are administered via syringe pump to achieve symptom control with a degree of sedation. In the Acute Trust during the pandemic, High Flow Nasal Oxygen (HFNO) (Frat, Goudet, Girault. *Rev Mal Respir.* 2013;30:627–43) provided symptom relief even when the lungs were severely impaired. Prior to introduction of HFNO on IPU, the maximum oxygen that could be delivered was 15L via a non-rebreathing mask. The use of high flow rates via nasal cannula causes drying/bleeding of the nasal mucosa and the cold temperature is frequently intolerable.

Aim To introduce HFNO for use in a hospice to improve symptom control in patients dying from ILD when appropriate.

Methods A patient in the Acute Trust was transferred to the hospice for end of life care. Despite receiving 15L oxygen via a non-rebreathing mask, his oxygen saturations were below 80%. Any care triggered panic attacks and desaturation episodes down to 58%. His deterioration prior to transfer had been very rapid. He had been in hospital for 3 months. He found morphine helpful but did not tolerate benzodiazepines. The company supplying the HFNO system provided training to staff.

Results HFNO provided immediate relief with improved oxygenation, reduced respiratory rate, reduced anxiety and an

ability to tolerate care. HFNO was well tolerated and the patient/family have spent quality time together. He is alive 3 months after transfer but is slowly/steadily deteriorating.

Conclusion HFNO is an effective way to provide symptom control in patients with end stage ILD, improving oxygenation and decreasing work of breathing and respiratory rate (Mauri, Turrini, Eronia, et al. *Am J Respir Crit Care Med.* 2017;195:1207–15; Vargas, Saint-Leger, Boyer, et al. *Respir Care.* 2015;60:1369–76). It is well tolerated (Cuquemelle, Pham, Papon, et al. *Respir Care.* 2012;57:1571–7) and its use has been pivotal in providing good end of life care for this patient. However it should be used judiciously and guidelines/indications for use should be developed.

P-186 **USING PERIPHERALLY INSERTED CENTRAL CATHETERS (PICC) TO PROMOTE THE PHILOSOPHY OF PALLIATIVE CARE: 'A PICC IS A GIFT'**

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Background Although Peripherally Inserted Central Catheters (PICCs) minimise procedure related pain and allow effective absorption of parenteral fluids and medications for patients when the oral route is no longer feasible, there is limited empirical data regarding their efficacy, safety and patient satisfaction in palliative care. A systematic literature review was undertaken on the role of PICCs in palliative care utilising GRADE (Grading of Recommendations, Assessment, Development and Evaluation) criteria. The level of evidence was MODERATE. This emerging literature suggests minimal pain and distress on insertion, limited complications and a favourable impact on quality of life.

Our patients Over a 12 month period, 24 patients underwent PICC insertion, 83% were women, 92% had solid tumours and the average age was 70 (range 36–94). 899 PICC days were monitored, the average number of days of placement was 37 (range 1–250). The indications for PICCs were hydration (92%), medication administration (92%) and blood sampling (88%). PICCs were inserted for all three indications in 19 (79%) patients. Three PICCs required replacement and one required removal. Only one of these was in relation to infection. This was an unconfirmed line infection and was on the advice of microbiology. The limited complications identified are likely due to all procedures being performed by the nurse-led Vascular Access Team, under aseptic conditions, utilising ultrasound and intracavitary ECG guidance and meticulous aftercare.

The benefits PICCs are synergistic with the philosophy of palliative care. A philosophy, which supports all symptoms to be managed, prevents new symptoms from arising and promotes opportunities for meaningful and valuable experiences. Administration of IV medication and blood products has facilitated the treatment of anaemia, infection, hypercalcaemia, refeeding syndrome and raised intracranial pressure whilst identification of anomalies in blood results supports clinical decision-making. Feedback from patients, families and staff has been overwhelmingly positive. In the words of the patient with the longest placement, a PICC is 'convenient and clean'.